News Release

Controller of the State of California - Kathleen Connell

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FOR IMMEDIATE RELEASE

STATE CONTROLLER TARGETS "VANISHING" MEDI-CAL VENDORS

Controller Connell Stops $17 Million In Medi-Cal Payments Over The Last Five Months;
Stresses Need To Halt Payments Quickly - Cites Collusion Among Fraudulent Providers

LOS ANGELES, November 3, 1999 -- State Controller Kathleen Connell today announced the dramatic results of a five-month audit crackdown on Medi-Cal providers by her office this year. Standing in front of one of the many empty offices that were former vendors to the Medi-Cal system, Connell described tactics that fraudulent providers are using to cheat California out of millions of dollars.

"These Medi-Cal vendors are playing a high-stakes game of 'bill-and-run.' The sole object of the game is to invoice the system for as much money as they can and disappear to a new location before the State catches them," said Connell. "Once we begin questioning invoices and withholding payments, we find patterns of vanishing providers with no forwarding addresses, disconnected telephones and no evidence that a business ever existed."

Since June 1999, the State Controller's Office (SCO) issued 50 audit reports of mostly Los Angeles-based Medi-Cal providers. SCO auditors found that nearly half of the 50 vendors or their suppliers do not exist -- some were closed when first contacted, others disappeared after being notified of a pending audit. In all cases, no forwarding address were left. In total, the Controller's Office disallowed more than $17 million in payments to suspected fraudulent providers and has demanded repayment. Based on these providers' billing patterns, the Controller estimates the audits saved California taxpayers another $48 million due to ceased billing activity.

"Decisive action is a key component to combating Medi-Cal fraud," Connell said. "These providers have the ability to quickly vanish into thin air. The challenge we face is to rapidly identify illusionary providers and cut off Medi-Cal payments originating from deceptive invoices. This process is critical to clogging the pipes of Medi-Cal fraud."

Connell also expressed concerns over apparent collusion among providers to commit fraud. She cited an example of two Medi-Cal operations owned by the same individual. Auditors noticed questionable billing patterns and initiated reviews of one operation. They found insufficient data to support claims paid to the provider. During this period, the owner sold the suspected fraudulent operation to another individual. When the SCO demanded reimbursement from the original owner, the new owner began billing the program, and received $565,000, under the previous owner's Medi-Cal number. Both providers shared the same accountant, supplier, and referring physician.

Because of these suspicious activities, the Controller's Office began to audit the new owner. When contacted, the new owner requested four weeks' additional time to prepare his records. When auditors returned they found an empty office, with no forwarding address. Connell is seeking repayment of $1.7 million from both owners.

"We believe that systematic fraud is epidemic in the Medi-Cal program," said Connell. "In many cases, fraudulent providers are just playing the odds that they won't get caught, and even if the do they simply reimburse Medi-Cal and consider previously ill-gotten payments as short-term loans."

"The encouraging news is that California is now on the road to Medi-Cal reform. Governor Davis signed two legislative measures, one sponsored by my office, that will prevent shell-game cons like this form occurring in the future. These anti-fraud initiatives now give Medi-Cal the authority to pre-screen providers and impose bonding requirements to recover funds from vanishing vendors."

Over the past three years, the Controller's Office has audited over 300 Medi-Cal providers. Of those audited, over 70% were referred to law enforcement agencies for prosecution as more than half of their billings were determined to be illegitimate. Those audited identified approximately $450 million in overpayments and cost avoidance to the state.

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